
# Government Response to the Health Select Committee's Report on Obesity

Presented to Parliament by
the Minister of Health
by Command of Her Majesty
December 2004

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## Introduction

The House of Commons' Health Select Committee published its report on Obesity on 10 May 2004. This Command Paper sets out the Government's response to the recommendations in that report.

We welcome the Committee's thorough and comprehensive investigation of the issues surrounding the growing problem of obesity. It complemented and directly contributed to the consultation and ongoing debate on *Choosing Health?*, and made an important contribution to the development of proposals for action on obesity set out in the *Choosing Health – Making healthy choices easier* White Paper that we published on 16 November.

The *Choosing Health* White Paper sets out a wide-ranging programme of action to improve health, change attitudes to health, and empower people to make healthy choices. It promotes the opportunity for healthy living in a manner and scale unseen before. Our commitment to addressing health inequalities permeates the whole document and many of the individual commitments. Many of the initiatives it contains will be targeted first at communities and groups where opportunities to choose health are least well-developed and most progress is needed.

Reducing obesity is one of the six overarching priorities of the *Choosing Health* White Paper. The White Paper sets out a comprehensive strategy for tackling obesity and proposes a wide range of action extending beyond the areas covered by the recommendations in the Committee's report. However, for the purpose of this response, we have focused on the specific recommendations of the Committee. In our reply to the recommendations we have, where appropriate, quoted verbatim the relevant commitments from the White Paper to enable the Committee to cross-refer. In compiling our response we have drawn together contributions from all Government departments implicated in the Committee's recommendations.

Other developments since the Committee produced its report have also addressed many of the concerns raised by the Committee. We have published the new *NHS Improvement Plan: Putting People at the Heart of Public Services* (2004). This strongly sets out the role that the NHS will have in developing into a health service rather than one that focuses primarily on sickness and how it will, in partnership with other organisations, make further in-roads into levels of obesity, smoking, and the other major causes of disease.

In addition, we launched the National Service Framework for Children, Young People and Maternity Services. This puts in place a comprehensive system for health that focuses on priority issues, including diet and physical activity.

We also, in July 2004, announced a new PSA target specifically concerning obesity. It is a joint target for the Department of Health, Department for Culture, Media and Sport and the Department for Education and Skills in recognition that cross Government action will be necessary if we are to successfully tackle this major public health problem:

> *"halting the year on year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole"*

The *Choosing Health* White Paper has now given us a solid foundation for future work. We look forward to building on the good practice models that have been achieved to date and taking a collaborative approach to addressing the unprecedented rise of obesity in England.

## Editorial Note

For ease of reference, and to assist with cross-referring in this document, we have numbered the Committee's recommendations to reflect the sequence in which they appeared in the *Conclusions and Recommendations* section of the Committee's report.

Where different recommendations addressed overlapping issues we have grouped them and provided a single overarching response.

## The Government's Response to the Select Committee's Recommendations:

**Recommendation 1 (paragraph 72): We recommend that work be urgently commissioned to establish a Food Survey that accurately reflects the total calorie intake of the population to supersede the flawed and partial analysis currently available. The Food Standards Agency and Scientific Advisory Committee on Nutrition should advise on this.**

Data on nutritional intake is currently collected through two key surveys. The National Diet and Nutrition Survey (NDNS) is jointly funded by the Food Standards Agency (FSA) and the Department of Health (DH) and managed by the FSA. The Expenditure and Food Survey (EFS) is managed by the Department for Environment, Food and Rural Affairs (DEFRA).

The NDNS is a comprehensive dietary survey and provides the best means of achieving accurate estimates of total calorie intake. The FSA began a review of the NDNS in December 2003. Key objectives of the review are reducing under-reporting and maintaining response rates, and developing a new structure and methodology. The FSA , as part of the review, has consulted the Scientific Advisory Committee on Nutrition and various stakeholders, and has commissioned further work to characterise misreporting in the survey. The revised NDNS will inform work on the diet and health goals in the *Food and Health Action Plan* that we will publish next year as part of the *Choosing Health* White Paper delivery plan, such as reducing intakes of salt, fat and sugar, helping consumers understand and make healthier choices.

DH, DEFRA and the FSA will continue to work together to explore the most effective way to combine the data from the NDNS and EFS to produce the best estimate of calorie intake in the general population. We shall also use the Health Survey for England in order to be able to monitor yearly body mass index, and consider ways of utilising data from primary care to provide more local information to enable better targeting of interventions.

**Recommendation 2 (paragraph 87): We recommend that the Department of Health commission research into the correlation between trends in alcohol consumption and trends in obesity.**

We acknowledge that calorie intake from alcohol can contribute towards overweight and obesity. However, whilst alcohol consumption is rising largely in those aged under 25, obesity is rising in all ages.

Trends in alcohol intake and obesity will be examined in the Health Survey for England and also the revised NDNS. This will need to take account of potential confounding factors such as calorie intake from sources other than alcohol and also energy expenditure through physical activity.

**Recommendation 3 (paragraph 153): We believe that an integrated and wide-ranging programme of solutions must be adopted as a matter of urgency, and that the Government must show itself prepared to invest in the health of future generations by supporting measures which do not promise overnight results, but which constitute a consistent, effective and defined strategy.**

There are no simple, short-term solutions for preventing or reducing obesity. A range of measures across Government at local, regional and national level is required, and individuals and communities will also have a role to play.

The *Choosing Health* White Paper sets the foundation for a long-term strategy to tackle obesity that will include a wide range of measures involving Government, the NHS, non-government organisations, industry, consumers and schools.

It sets out a range of measures including:

- raising awareness through a new strategy to actively promote health – including a new cross-government campaign on obesity;
- improving access to healthier foods, including working with industry;
- improving access to physical activity – for example through sports and active travel;
- restricting the promotion of unhealthy foods to children;
- improving nutrition in schools;
- procurement guidance on food for public bodies;
- developing a comprehensive care pathway for obesity, to provide a model for prevention and treatment for the NHS; and
- training and support for NHS staff and introduction of accredited health trainers.

These White Paper commitments, and many others, are addressed in more detail in the responses we have given to the Committee's other recommendations.

The White Paper delivery plan that we will publish early next year, together with discrete national delivery plans focusing on nutrition and activity (the *Food and Health Action Plan* and the *Physical Activity Plan*) will set out how we will deliver our White Paper commitments and also the PSA target to halt the rise in obesity.

**Recommendation 4 (paragraph 159): We recommend that a specific Cabinet public health committee is appointed, chaired by the Secretary of State for Health, and that one of its first tasks is to oversee the development of Public Service Agreement (PSA) targets relating to public health in general and obesity in particular, across all relevant government departments.**

In May 2004, the Prime Minister announced the establishment of a Cabinet Committee on Public Health, chaired by John Reid, the Secretary of State for Health. Its terms of reference are "to oversee the development and implementation of the Government's policies on public health and reduce health inequalities". This will include oversight of the new PSA target announced on 12 July 2004 of *"halting the year on year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole"*. The PSA target is a joint target led by DH , in conjunction with the Department for Culture, Media and Sport (DCMS) and the Department for Education and Skills (DfES).

**Recommendation 5 (paragraph 160): We recommend that the Government should consider either expanding the role of an existing body or bodies, such as the Food Standards Agency or Central Council of Physical Recreation (or linking these), or consider the creation of a new Council of Nutrition and Physical Activity to improve co-ordination and inject independent thinking into strategy.**

We will support the setting up of a "national partnership for obesity". The partnership will act to promote practical action on the prevention and management of obesity and as a source of information on obesity (for both diet and physical activity) and evidence of effectiveness.

**Recommendation 6 (paragraph 171): We recommend that the Government adopt a health education campaign dedicated exclusively to tackling obesity, which should follow the model used in the recent anti-smoking campaign.**

**Recommendation 7 (paragraph 171 and 181): Such a health promotion campaign should be launched as soon as possible, with the FSA advising on the nutritional content of such promotion, and the Activity Co-ordination Team, if this remains operational, or alternatively Sport England through its links with Move4Health advising on the physical activity dimension.**

One of the key themes in the *Choosing Health? Choosing a Better Diet* and *Choosing Activity* consultations was how to provide individuals and communities with accurate information about healthy lifestyles, including diet, nutrition and activity that would encourage and support behaviour change.

Having considered the responses to the consultation:

- The Department of Health will lead on action to promote health by influencing people's attitudes to the choices they make through a strategy that extends across all aspects of health and involves a broad range of different Government departments and agencies such as those covering interests in the NHS, food, sport, the environment and transport. The Department of Health will appoint an independent body to implement the strategy on its behalf.
- The strategy will include new communications building on previous successful campaigns on smoking, salt, mental wellbeing and sexual health and extend to include information on obesity, healthy eating and physical activity in different groups.
- It will bring together messages raising awareness of health risks and information about action people can take for themselves to address those risks – for example, by changing their diet, taking more exercise or seeking advice through telephone helplines, local health improvement services. Early focus will include:
  - *Obesity* – a new cross-government campaign to raise awareness of the health risks of obesity, and the steps people can take through diet and physical activity to prevent obesity.

This, as well as other campaigns on sexual health, smoking and alcohol, will operate at a national and regional level and use creative social marketing techniques and new technology. The campaigns will promote key messages and local services through a variety of channels, for example in schools and workplaces as well as through health professionals.

The most successful campaigns have been those that reach people through a number of sources that actively and consistently promote health. We will build on this by:

- funding specific campaigns through nongovernmental organisations like the British Heart Foundation, Cancer Research UK and Age Concern;
- encouraging industry involvement through use of consistent messages on health like 5 A DAY in supermarkets and on food packaging to reach people when they are making choices;
- working with the sports and recreational activity sectors to deliver positive innovative messages about healthy lifestyles through, for example, football, walking, cycling and fitness centres; and
- linking into activity in communities, schools and workplaces to make messages relevant to different people's lives.

In the longer term we expect to see a significant part of the strategy delivered through campaigns that are jointly funded by government and industry.

**Recommendation 8 (paragraph 174): We recommend that the Government take steps to reformulate the Food Technology curriculum, so that children of all ages receive practical training in how to choose and prepare healthy food which they can put into practice in their daily lives.**

The National Curriculum and curriculum guidance for early years already offers schools and nurseries a great deal of flexibility in teaching about food – where it comes from, how it is produced, developing practical cooking skills, diet, nutrition, making healthy choices – and accommodates the recommendations above. Learning about food goes across the curriculum.

Food Technology is a **statutory requirement** at primary level and more than 90% of secondary schools provide it for their pupils. Nutrition and practical food activities are an integral part of the food technology curriculum for pupils of all ages – they are **not** optional. The Ofsted publication *'Characteristics of Good Practice in Food Technology'*, identifies four key concepts for all school pupils to learn by age 14 and, for those who choose to continue, from age 14-19.

We are promoting practical cooking skills through local partnerships within the context of the *National Healthy Schools Standard*. Food Technology teaches pupils to make informed choices about the amount and variety of food eaten and how to combine and cook pre-prepared and fresh ingredients to maintain the balance of good health. Pupils need to know how to store and prepare all types of food safely and hygienically.

The DH will launch in December 2004 materials to support the implementation of the *School Fruit and Vegetable Scheme* in schools, which will support messages taught in the curriculum. The materials include step-by-step guidance, a Foundation Stage curriculum pack, a Key Stage 1 curriculum pack and materials to support curriculum teaching and wider school engagement.

The DH/DfES *Food in Schools* programme is assisting schools across England to implement the whole school approach to healthy eating and drinking. Over 700 local food partnerships have been established, where secondary school food specialists train their primary school colleagues in teaching diet, nutrition and cooking.

**Recommendation 9 (paragraph 175): We recommend that delivery of the Food Technology curriculum should be rigorously inspected by Ofsted.**

The *Future of Inspection* proposals for schools will mean the introduction from September 2005 of shorter, sharper inspections. There will be less detail on individual subjects than under the current model, with reports of 6-10 pages compared with current 30-40 pages at present. However, Ofsted will review all subjects across the curriculum through additional sample surveys, reporting annually through HMCI's annual report and in detail every three years. Food technology will be covered within this programme of work.

In addition, Ofsted will undertake a survey on the contribution of education to pupils' health that will include looking at a range of relevant subjects, including food technology as part of design & technology.

From 2005, all relevant inspections for services for children (including those by Ofsted) will be carried out under a single overall inspection framework. This will focus on how services contribute towards the wellbeing of children and young people, including their physical and mental health.

**Recommendation 10 (paragraph 181): We recommend that the Government should concentrate its efforts not solely on informing choice, but also on addressing environmental factors in order to make healthy choices easier to make.**

Identifying the key barriers to choosing a better diet, including environmental factors, was part of the *Choosing Health?* and *Choosing a Better Diet* consultations. It is unquestionably easier for some people to make healthy choices than others and environmental factors play a part. Action by local authorities working with local communities, business and voluntary groups to tackle local health issues makes a difference to the opportunities for both adults and children to choose healthier lifestyles.

Some environmental barriers are already being addressed under the 5 A DAY programme, which aims to improve access to fruit and vegetables. This includes 5 A DAY community initiatives based in the 66 most deprived Primary Care Trusts (PCTs) supported by £10 million from the Big Lottery Fund.

The DH is committed to funding similar community food initiatives, following evaluation of the lottery-funded pilot initiatives, in more PCTs from 2006. The focus will be on deprived communities and will build on the lessons to come out of the evaluation of lottery-funded initiatives.

In addition:

- we will extend the current Healthy Communities Collaborative to more deprived communities from 2006, and we will use collaborative techniques to support action through local partnerships;
- we will publish revised guidance on health and neighbourhood renewal, early in 2005, to support local action to address health inequalities and deliver neighbourhood renewal;
- beginning in spring 2005 we will pilot a new approach in 12 localities, *Communities for Health*, to promote action on locally chosen priorities for health across the local voluntary sector, the NHS, local authorities, business and industry;
- working with local government and other partners including PCTs and children's trusts, from 2005 we will pilot Local Area Agreements in 21 areas to secure local delivery of national priorities, reinforce joint working and bring together different funding streams in ways that reflect local priorities;
- from April 2005, PCTs will develop targets to meet the needs of people living in their area that are agreed with local partners to meet national targets and priorities set by *Choosing Health* and the *NHS Improvement Plan*; and
- we will build on the *Sustainable Travel Towns* pilots to develop new guidance on "whole town" approaches to walking, cycling and public transport.

Our Sure Start initiative includes local programmes and children's centres which have taken steps to improve access to healthy food in deprived areas, such as arranging transport to supermarkets for families living in disadvantaged areas with few or no opportunities to buy fresh food at affordable prices. In addition, many Sure Start local programme areas that lacked safe play areas for very young children have developed indoor and outdoor play areas. This has involved upgrading existing play areas and building new ones.

In addition, DCMS has announced that £200 million will be made available for the provision of good quality play spaces to enable children to become more physically active, increase their confidence levels and feel part of their community.

**Recommendation 11 (paragraph 192): While we would not want to go so far as to call for an outright ban of all advertising of unhealthy food, given the clear evidence we have uncovered of the cynical exploitation of the pester power we would very much welcome it if the industry as a whole acted in advance of any possible statutory control, and voluntarily withdrew such advertising.**

**Recommendation 12 (paragraph 194): We would like the Secretary of State for Culture, Media and Sport to review the whole marketing function. In particular, to address the impact of product endorsement of less healthy food by sports stars, and other celebrities. Assuming the food and advertising industry is genuine in its desire to be part of the solution, a starting point for this would be for companies to agree clear public health targets.**

The advertising and promotion of unhealthy food to children was one of the key issues raised in responses to the *Choosing Health?* and *Choosing a Better Diet* consultations. There was a strong emphasis in responses to the consultation that the Government should take steps to protect children from the effects of promotion of unhealthy foods. The FSA has recently undertaken a review of food promotion to children and has published its Action Plan on Promotion of Foods to Children, which includes proposals for restrictions on advertising of foods to children. Ofcom have also recently undertaken a review of food advertising to children on television.

In line with the research conclusions and the responses to the consultation, the Government considers there is a strong case for action to restrict further the advertising and promotion to children of those foods and drinks that are high in fat, salt and sugar. To have maximum effect, action needs to be comprehensive and taken in relation to all forms of food advertising and promotion, including:

- broadcast
- non-broadcast
- sponsorship and brand-sharing
- point of sale advertising, including vending in schools
- labels, wrappers and packaging

On television we will work with the broadcasting and advertising sectors on ways to help drive down levels of childhood obesity. In particular we will look to Ofcom to consult on proposals on tightening the rules on broadcast advertising, sponsorship and promotion of food and drink and securing their effective implementation by broadcasters in order to ensure that children are properly protected from encouragement to eat too many high fat, salt and sugar foods – both during children's programmes and at other times when large numbers of children are watching. It should also include options for broadcasters and advertisers to participate in healthy living promotions.

We will work with industry, advertisers, consumer groups and other stakeholders to encourage new measures to strengthen existing voluntary codes in non-broadcast areas, including:

- setting up a new food and drink advertising and promotion forum to review, supplement, strengthen and bring together existing provisions; and
- contributing funding to the development of new health initiatives, including positive health campaigns.

The Government is committed to ensuring that measures to protect children's health are rigorously implemented and soundly based on evidence of impact. We will therefore monitor the success of these measures in relation to the balance of food and drink advertising and promotion to children, and children's food preferences to assess their impact. If, by early 2007, they have failed to produce change in the nature and balance of food promotion, we will take action through existing powers or new legislation to implement a clearly defined framework for regulating the promotion of food to children.

**Recommendation 13 (paragraph 195): We recommend that Ofcom be asked to review the role of the Advertising Standards Authority with a view to improving its effectiveness.**

The Advertising Standards Authority (ASA) regulates all non-broadcast advertising. This aspect of the advertising industry lies outside Ofcom's remit. We believe that the ASA is an effective self-regulatory body and that it enjoys national and international respect. We understand that it has already responded to the Committee's criticisms.

Ofcom has worked closely with the ASA on proposals for a new system of co-regulation for broadcast advertising. These proposals were agreed by Parliament in July and the new system launched on 1 November 2004. Parliament has placed clear duties on Ofcom in relation to broadcast advertising to children and it must ensure that any co-regulatory system is robust enough to discharge those duties.

**Recommendation 14 (paragraph 199): Parents, teachers and school governors must all be fully engaged in tackling obesity, which should command a high priority on school board agendas.**

**Recommendation 15 (paragraph 200): We recommend that all schools should be required to develop school nutrition policies, in conjunction with parents and children, with the particular aim of combating obesity, but also of improving nutrition more generally. In conjunction with this, the Government should issue guidance to all schools strongly recommending that they do not accept sponsorship from manufacturers associated with unhealthy foods or install vending machines selling unhealthy foods. The guidance should also give firm support for the replacement of existing vending machines with ones selling healthy foods and drinks.**

We are committed to developing approaches that take account of health in everything a school does. In terms of action on nutrition, that means we want to see all schools:

- deliver clear and consistent messages about nutrition and healthy eating;
- provide opportunities to learn about diet, nutrition, food safety and hygiene, food preparation and cooking as well as where food comes from; and
- actively promote healthy food and drink as part of an enjoyable and balanced diet and restrict the availability and promotion of other options.

The *National Healthy Schools Programme* is working with over 10,000 schools to develop a whole school approach to health:

- The Government has a vision that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009.
- From 1 April 2005, a Healthy School will provide:
  - a supportive environment, including policies on smoking and healthy and nutritious food, with time and facilities for physical activity and sport both within and beyond the curriculum; and
  - comprehensive Personal, Social and Health Education.

The Programme will therefore focus particularly on key health priorities and will contribute directly to the delivery of the national target on childhood obesity. This new vision of healthy schools will be supported by the *Healthy Living Blueprint*. The Blueprint and supporting website (www.teachernet.gov.uk/healthyliving ) raises the issue of healthy living with both schools and early years settings and directs them to where they can access guidance, support and information. It has five key objectives, covering all aspects of food and drink during the school day, including vending machines, school meals, packed lunches, snacks, out of school clubs and drinking water. Our aim is that, over time, all schools will make progress in each objective. These initiatives will be supported through the new approach to schools inspections that will be implemented by Ofsted from September 2005 – more detail is given in our response to recommendation 9.

In addition, the DH/DfES *Food in Schools* programme is bringing together information to assist schools in implementing the whole school approach to healthy eating and drinking. This will be available from early 2005 and will pull together all key information in one place, including guidance on healthier breakfast clubs, tuck shops, vending machines, lunch boxes, cookery clubs, as well as water provision, growing clubs, the dining room environment, 5 A DAY, school meals and curriculum links. This package will be fully integrated into the *National Healthy Schools Programme*.

There was a clear call in the responses to the *Choosing Health?* consultation for restrictions on the promotion and sponsorship of food and drink in schools. As noted in the *Healthy Living Blueprint*, a challenge for schools is to balance the benefits of food promotional activity – including sponsorship, advertising and branding of materials – with the ethos of a healthy school and whole school approach to healthy eating. This issue will be considered further as part of our comprehensive approach to promotion of foods to children, outlined in our response to recommendations 11–12 above.

**Recommendation 16 (paragraph 248): We recommend that the Department for Education and Skills extend the scope of the Food Standards Agency review of the implementation of nutritional standards, with a view to developing appropriate nutrient based standards for school breakfasts.**

**Recommendation 17 (paragraph 249): We recommend that the Department for Education and Skills to take steps to ensure that all children eat a healthy school meal at lunchtime, both through improving the provision of attractive and palatable 'healthy' options, and through restricting the availability of unhealthy foods. The Government should shift from the current 'food-based' standards toward the 'nutrition-based' standards being introduced in Scotland. The quality of school meals should also be taken into account by Ofsted inspections.**

School lunches provide a significant proportion of children's food and nutrient intake and can encourage pupils to eat more fruit and vegetables and develop a taste for food low in salt, sugar and fat. Much more needs to be done to improve the quality of meals that schools provide and also to influence the food choices that pupils make.

That is why we will invest over the next three years to improve nutrition in school meals by:

- revising both primary and secondary school meal standards, to reduce the consumption of fat, salt and sugar and to increase the consumption of fruit and vegetables and other essential nutrients. We will strongly consider introducing nutrient-based standards. Ofsted inspectors will be looking at healthy eating in schools, and will take account of any school meals provided in doing so;
- subject to legislation, extending the new standards to cover food across the school day, including vending machines and tuck shops; and
- supporting schools to provide the best meal service possible – for example through new guidance on food procurement for heads and governors, and improving training and support for school meal providers and catering staff.

This investment will enable schools to have more confidence in trying out new approaches and investigating whether they can build links with the local community, working with local providers and sourcing local produce.

Additionally, following successful pilots in over 300 schools, a comprehensive *Food in Schools* package is being developed to support implementation of the whole school approach to healthy eating and drinking. Available from early 2005, this package will provide guidance and resources for schools to encourage, for example:

- cooking clubs where children prepare and cook healthy food in a fun and enjoyable way
- how to set up and manage healthy vending machines
- healthier breakfast clubs
- tuck shops
- lunch boxes
- water provision
- growing clubs
- the dining room environment

**Recommendation 18 (paragraph 216): We recommend that the Government introduce legislation to effect a 'traffic light' system for labelling foods, either 'red-high', 'amber-medium' or 'green-low' according to criteria devised by the Food Standards Agency, which should be based on energy density. This would apply to all foods.**

One of the issues raised in the *Choosing Health?* and *Choosing a Better Diet* consultations was the need for simpler and better understood labelling of food to enable people to better understand the nutrient content of food and assist people to make healthier choices.

The DH has started work with the FSA to develop criteria that take account of fat, salt and sugar levels to indicate the contribution a food makes to a healthy balanced diet.

As a result, by mid 2005 we aim to have introduced a system that could be used as a standard basis for signposting food. This will build on the nutrient criteria for the 5 A DAY logo. The criteria will also be used among other things to identify which foods can be promoted to children – see also our response to recommendations 11 and 12. The criteria for use of the 5 A DAY logo will be extended to processed foods and to foods targeted at children.

We will work with the food industry to develop the signposting approach further on the completion of FSA consumer research. Our goal is, by early 2006, for there to be:

- a clear straightforward coding system;
- that is in common use; and
- that busy people can understand at a glance which foods can make a positive contribution to a healthy diet, and which are recommended to be eaten only in moderation or sparingly.

**Recommendation 19 (paragraph 222): We recommend that, rather than targeting sugar and fat separately, Government should focus on reducing overall energy density of foods, and should work with the Food Standards Agency to develop stringent targets for reformulation of foods to reduce energy density within a short time frame. While we expect that reformulation could be achieved through voluntary arrangements with industry, and while we believe that the introduction of legislation in respect of labelling will encourage industry to make the entire product range healthier, the Government must be prepared, in the last resort, to underpin this with tougher measures in the near future if voluntary measures fail.**

**Recommendation 20 (paragraph 230): We recommend that in the short term, the Government must work with the food industry to ensure that 'healthy' versions of foods, with reduced calories and fat, are available at an affordable price.**

Health Ministers and the FSA are leading discussions with industry to identify and implement a range of proposals to increase opportunities for people to make healthy choices in what they eat. These are aimed at:

- increasing the availability of healthier food, including reducing the levels of salt, added sugars and fat in prepared and processed food and drink and increasing access to fruit and vegetables;
- reversing the trend towards bigger portion sizes; and
- adopting consistent and clear standards for information on food including signposting.

We will also work with industry to develop voluntary action based on:

- long-term and interim targets for reducing sugar and fat levels in different categories of foods – compliance will be monitored through regular surveys; and
- development of guidance on portion sizes to reduce energy, fat, sugar and salt intake.

We will work with the farming and food industries to coordinate action, including action to take forward policies in the *Choosing Health* White Paper, through a *Food and Health Action Plan* to be published in early 2005. This will coordinate with, and contribute to the delivery of, the *Strategy for Sustainable Farming and Food* (SSFF). As part of that we will ensure that the regional delivery plans of the SSFF all include commitments on nutrition. This will be backed up with wider action in the *Food Standards Agency Strategic Plan*.

Catering providers in both the public and private sector have an important role to play in influencing access to healthier foods. Public procurement of food through the NHS, the Prison Service and the Ministry of Defence offers an opportunity to demonstrate best practice. We will develop nutritional standards for all foods provided by these organisations and other public bodies – building on the work in schools. Our intention is to increase access to a range of healthier foods and will take account of the different formats of food provision – restaurant, fast food, vending etc.

**Recommendation 21 (paragraph 228): Rather than taxing unhealthy foods, we recommend that the Government should keep an open mind on this issue, and monitor closely the effect of fat taxes introduced in other countries. We also recommend that the Government should take steps to address the anomalies in the current arrangements for VAT on unhealthy 'treat' foods, as it is clearly ludicrous that VAT is levied on ice cream and fizzy drinks but not on Bourbon biscuits or cakes.**

We remain committed to maintaining the existing zero rate on VAT for food under long-standing agreements with our European partners. There are difficulties in principle and practice with the further use of tax instruments to promote public health. The Government remains to be convinced of any possible health benefits of aligning the VAT rate on any given products.

We intend to discuss with the food industry how they might contribute to funding national campaigns and other national initiatives to promote positive health information and education – see also our response to recommendation 7.

**Recommendation 22 (paragraph 237): As a matter of urgency, the Government must redouble its efforts to reform the CAP as part of the public health agenda. Progress on the CAP will be extremely difficult unless public health is given much greater emphasis in Europe. Government to use its influence, and its forthcoming presidency, to encourage the Commission to reconsider the Treaty of Rome and put public health on an equal footing with trade and economics.**

**Recommendation 23 (paragraph 238): Government, led by Treasury, should emulate the Swedish Government and produce a Health Audit of the CAP, and build a stronger alliance of Health Ministries to combat other interests protecting the status quo in public policy.**

We have long advocated reform of the Common Agricultural Policy (CAP) and in our response to the *Report of the Policy Commission on the Future of Farming and Food* we gave a commitment that our policy on reform would be informed by the analysis of the health impacts of food production and agriculture expenditure.

We played a leading role in securing agreement in the EU in June 2003 and April 2004 to major CAP reforms which will break the link between the bulk of subsidy paid to farmers and what and how much they produce. We want to continue to move the CAP away from market manipulation, which has been costly and damaging for the environment, trade and development, and free farmers to produce the food that consumers want. The reforms also include a reduction in the support price for butter, which should lead over the next few years to the disappearance of schemes to promote the consumption of butter surpluses. We will also be pressing for a complete end to the subsidised destruction of fruit and vegetables. DEFRA and DH are assessing the impact of any reductions in the price of sugar as a result of CAP reform on sugar consumption in the population and its impact on health.

Collectively, these changes should remove a significant proportion of the price distortions between commodities and effectively neutralise that element of the CAP's impact on consumption patterns. We believe further beneficial reform can be achieved without the need to reconsider the Treaty of Rome.

A good deal of analysis already exists on the health implications of EU agriculture policy, including the studies and reports cited by the Committee. These have already informed the debate about CAP reform and we do not believe another specific study is needed in order to enable us to continue to make a strong case for further change.

**Recommendation 24 (paragraph 241): As part of their health pricing strategies, supermarkets must commit themselves to phasing out price promotions that favour unhealthy foods, and also stop all forms of product placement which give undue emphasis to unhealthy foods, in particular the placement of confectionery and snacks at supermarket checkout. Alongside this, all sectors of the food industry should collaborate in the phasing out of super-sized food portions. We commend fast-food outlets for offering fruit and salad options, though we request that these should be promoted more effectively than at present. Those companies who do not comply with Government guidance on healthy pricing, including product placement and super-sizing, should be publicly named and shamed.**

There are a range of creative ways for positive campaigns to promote healthy lifestyles in order to counteract the impact of advertising of high fat, sugar and salt foods, and we are keen to see these used by industry. We welcome all moves made so far by industry to broaden the range of healthy choices available, but believe there is scope for further action.

We refer the Committee to our response to recommendations 19 and 20 in which we set out our work with industry to identify and implement a range of action to increase opportunities for people to make healthy choices in what they eat in relation to reformulating foods. We also refer the committee to our response to recommendations 11 and 12, in which we set out our proposals for action across all forms of food advertising and promotion.

**Recommendation 25 (paragraph 276): We recommend that the aspiration should be for schoolchildren to participate in three hours per week of physical activity, as recommended by the European Heart Network.**

**Recommendation 26 (paragraph 277): We believe that the Brent Project is a fascinating pilot and would like to see it rigorously evaluated. Given its potential importance as a model, we also think it would be helpful if the Department's favourable initial appraisal of the scheme were supported by funding.**

**Recommendation 27 (paragraph 278): We recommend that the Curriculum Authority should address ways of diversifying organised and recreational activity in schools to embrace areas such dance or aerobics to broaden the appeal of PE and to counteract the elitism, embarrassment and bullying that the changing room sometimes creates.**

Encouraging physical activity in early years sets important foundations. Physical activity should be an important part of early years learning. The Government is investing more than £1 billion in a major change to the role and delivery of PE and school sport. We are seeking to establish a sustainable infrastructure for high quality PE and school sport, reversing years of decline and driving whole school improvement. We need to ensure that teachers have the tools, time and support that they need and that schools are not burdened unduly. DfES and DCMS set out expectations of what high quality PE and school sport looks like in March 2003. This was supplemented by more detailed guidance in March 2004. This is being assessed independently by Ofsted in its annual reports on the delivery and impact of the national PE School Sport and Club Links strategy.

We want all children to have access to at least two hours of high quality PE and school sport every week. The PSA target rightly focuses on pupils' participation in PE and school sport, with a target of 75% of pupils receiving at least two hours high quality PE and sport each week by 2006. This target has been extended to 85% of pupils by 2008. However, we expect **all** pupils to be offered the two hour entitlement. We want them to have a range of exciting and innovative choices – recognising that the traditional sports are not likely to appeal to all young people. We want to encourage those young people who tend not to enjoy sport to try other non-competitive forms of physical activity like dance, which can contribute to good health and well-being.

Dance is a key element of the PE National Curriculum. It is compulsory at key stage 1 and 2 and pupils can choose to pursue it at key stages 3 and 4 if they wish. The 2003-04 PE, School Sport and Club Links survey – published in April 2004 – was the largest and most comprehensive survey of school sport in this country. It found that 94% of the 6500 schools which completed the survey offer dance to their pupils. The survey also found that schools are increasingly offering fitness training – including aerobics.

We want PE and sport facilities, particularly changing and washing facilities, that are safe, attractive and designed with cultural and body image sensitivities in mind; and to promote a positive attitude to personal hygiene – that will be an important part of designing PE facilities as part of the *Building Schools for the Future Programme*.

Children should be encouraged to walk or cycle part or all of the way to school wherever this is safe and practical. We expect schools to work with their local authority school travel advisers, and put in place school travel plans that will identify things that schools, pupils, parents, highways and local education authorities can do to reduce car use on the school run – cycle and pedestrian training, secure cycle storage, improved road crossings and cycle paths, traffic calming, 'park and stride' facilities. DfES and the Department for Transport (DfT) are spending a total of £50m this and next year in supporting schools and encouraging them to develop School Travel Plans. DfT is investing in programmes to link the existing National Cycle Network to hundreds of schools enabling more children to walk or cycle to school.

The PE and School Sport Investigation, being undertaken by the Qualifications & Curriculum Authority is identifying and disseminating examples of best practice. This includes tailoring the curriculum and out of school hours opportunities to the likes and needs of all children (particularly those who have, traditionally, been marginalised by sport) and ways in which schools combat bullying and peer pressure.

DfES is funding the evaluation of the Brent North proposal.

**Recommendation 28 (paragraph 279): We recommend that the Ofsted inspection criteria should be extended to include a school's performance in encouraging and sustaining physical activity.**

The revised statutory purposes of inspection for the proposed new school inspection model, do pick up physical development as part of assessing the schools contribution to the well-being of children in relation to the five outcomes for children. This will be reported on in all cases and will include details of any extra curricular physical activities and sport which is available to pupils. We do not think it is necessary to amend the criteria further. Ofsted is consulting on the new inspection framework, prior to its introduction in September 2005. Within the new framework, small teams of inspectors will visit schools every three years, compared to the current six year cycle. The reports will be shorter (6-10 pages compared with current 30-50 pages) so it will not be possible to capture detailed information – see also our response to recommendation 9.

**Recommendation 29 (paragraph 280): We recommend that the Department for Education and Skills, as part of its wider work to improve self-esteem and self-confidence amongst school children, should ensure that each school, as part of its policy against bullying, remains alert to the particular issue of bullying of children who are overweight or obese. Teachers should receive training in children's diet, physical activity levels, and how to help obese children combat bullying, without further stigmatising them.**

The *National Healthy Schools Programme* advocates a 'whole school' approach to health and wellbeing. The theme of emotional health and wellbeing includes bullying of any kind. 2,786 schools have already achieved the theme and many more are working towards it.

We are working through the PE School Sport Club Links strategy to ensure continuing professional development programmes provide teachers with the knowledge and skills to:

- identify and support children who may be at risk from obesity; and
- work in partnership with the health sector to provide appropriate services.

Children, young people and parents can also expect support from the school nursing service – see our response to recommendations 44/45 for more detail of proposals for modernising and expanding the service. They can expect:

- to be involved in assessing their health needs and to be supported in caring and promoting their own health through Personal Health Guides;
- to have access to sensitive, confidential, expert health advice and support for their emotional wellbeing and health behaviours, including access to information through websites and text messaging; and
- to have any health, medical and development problems identified and addressed in a way that minimises the impact of clinical conditions and disability on learning. The school nursing service will include:
  - appropriate training to support individual children with medical needs in school; and
  - to work with colleagues to ensure the school environment supports health improvement.

**Recommendation 30 (paragraph 292): We believe that a National Walking Strategy should be incorporated into a wider anti-obesity strategy.**

National and international evidence suggests that a key means of tackling obesity is to build physical activity into our daily lives and this is an approach that the Government and other agencies are seeking to promote.

The DfT published *Walking and Cycling: An Action Plan* on 16 June 2004. The report contains more than 40 practical actions from across Government aimed at increasing levels of walking and cycling. The actions in respect of walking are aimed at both improving the physical environment to make walking a more viable and attractive option by means of improvements to the planning regime and rights of way, and to persuade more people to choose to walk more often, through improved marketing of walking and training.

The action plan fully recognises the public health benefits of walking and cycling and forms part of the Government's collaborative effort to raise levels of physical activity and improve public health. Not only DH , but also DCMS , DEFRA , DfES, the Office of the Deputy Prime Minister (ODPM), Sport England and The Countryside Agency were involved in producing the document. Implementation of the action plan will be coordinated with delivery of the Government's Obesity PSA target and the *Physical Activity Plan*.

Building on the success of the Local Exercise Action Pilots, we will invest over the next three years in initiatives to promote physical activity supported by guidance to promote best practice. This will include:

- a Physical Activity Promotion Fund to roll out evidence based physical activity interventions – linked where appropriate to local health trainers and developing obesity care services;
- regional Physical Activity Coordinators to coordinate delivery of activity interventions and support planning for use of the Fund, linked to plans to tackle obesity; and
- guidance on what works for local authorities, PCTs and voluntary bodies, backed up by annual stakeholder events to promote best practice.

**Recommendation 31 (paragraph 297): Commercial firms issuing pedometers also issue guidance agreed with Sport England and the FSA on the recommended activity levels per day and on the correlation between steps taken and calories consumed.**

As part of our plans set out in the *Choosing Health* White Paper to market health, we will commission practical guidance on how to meet the Chief Medical Officer's physical activity recommendation including the use of pedometers. Such guidance will be available for others, including commercial firms, to use.

**Recommendation 32 (paragraph 299): We recommend that the Department of Health coordinate inter-departmental activity with a view to achieving wide-spread use of pedometers in schools, the workplace and the wider community.**

We have been encouraged by the results of the pedometer pilot which DH ran with the Countryside Agency and British Heart Foundation last year. Evaluation of the pilot concluded that when distributed by healthcare professionals adults increased their walking by on average 1,600 steps a day.

Working with the Countryside Agency, DEFRA and other partners, we will encourage health professionals across PCTs to use pedometers in clinical practice, with coverage of all areas by the end of 2005.

We are also working with the Youth Sport Trust to pilot the use of pedometers in schools – both as a tool to support a wide range of curriculum topics and to increase awareness amongst pupils of the need to be active.

**Recommendation 33 (paragraph 316): We would like the Department of Health to have a strategic input into transport policy and we believe it would be an important symbolic gesture of the move from a sickness to a health service if the Department of Health offered funding to support the Department for Transport's sustainable transport town pilots.**

Since the inception of the Activity Co-ordination Team (ACT), there has been a close working relationship between DH and DfT. This has covered the development of transport policy (e.g. see Recommendation 30 above), *Choosing Health* and the economic assessment of transport schemes.

Following evaluation we will build on the *Sustainable Travel Towns* pilots to develop guidance for local authorities, PCTs and others on whole town approaches to shifting travel from cars to walking cycling and public transport.

DH and DfT are also working in partnership to drive forward action to implement the new National Standard for cycle training for children across England by 2005-06 by:

- establishing a formal cycle training and curriculum body – the Cycle Training Reference Group;
- funding instructor training schemes and accrediting existing training schemes and centres; and
- providing a help desk and web database of trainers to support local authorities, schools and parents administer the National Standard.

**Recommendation 34 (paragraph 321): Major planning proposals and transport projects are already subject to environmental impact assessment; a health impact assessment should also be a statutory requirement. Would enable health to be integrated into the planning procedure.**

To avoid the risk that in some cases, interventions may contribute to widening health inequalities, government departments, and particularly the ODPM and DH, will ensure that initiatives and programmes are health inequality "proofed". This will involve consideration of whether any policy changes or remedial actions are necessary to prevent any negative effects on health inequalities. The impact of "non-health" interventions on population health should also be more routinely considered both before implementing policies (through Health Impact Assessments, for example) and afterwards through evaluation.

We will build health into all future legislation by including health as a component in regulatory impact assessment.

**Recommendation 35 (paragraph 328): We recommend that the Department of Health in conjunction with the Department for Work and Pensions and the Department of Trade and Industry, first organises a major conference to promote awareness of obesity in the work-place and then engages in an ongoing process of consultation to see how measures can be taken to address sedentary behaviour. We recommend that these Departments consult with the Treasury to see what fiscal incentives can be provided to promote active travel.**

Working with Sport England, the British Heart Foundation, Business in the Community and the Big Lottery Fund, we will establish pilots to develop the evidence base for effectiveness on promoting health and wellbeing through the workplace. Each pilot will focus on a specific type of workplace such as an NHS organisation, a local council or a business. We believe it would be premature to stage a conference on this issue before the evidence of effectiveness has been established but intend to fully disseminate the findings of the pilots. A conference may well be an effective means of doing so at that point.

We have agreed with Investors in People (IiP) that they will develop a new healthy business assessment, in conjunction with DH, identifying the advantages for business and employees in investing in staff health and building on mechanisms already available to businesses from IiP covering issues such as work – life balance. This work will be incorporated into the IiP Standard when it is next reviewed in 2007.

The Inland Revenue rules already allow employers to help staff in a number of ways to increase their physical activity by cycling to work, including through tax efficient bike purchase from salary. The use of these concessions is low, in part because of lack of knowledge and understanding. The DfT will work with the cycle industry to produce user-friendly guidance on the tax efficient bike purchase scheme to increase the use of the scheme and promote cycling.

**Recommendation 36 (paragraph 329): We also recommend that the public sector looks to set an example in finding creative ways of encouraging activity in everyday life, and that this is built into a PSA target for each Department.**

We are aware that Government and the public sector have real issues to tackle in improving the health of our workforce. Government recognises that individual employees alone cannot achieve this improvement, but need help from their public service employers. We want to learn from best practice elsewhere and find practical ways to promote the health of public sector employees, so that we lead by example as employers.

Sport England will provide a free consultancy service to Government Departments on how they can encourage and support their workforces to be more active in the workplace.

Furthermore, we will disseminate the learning from the Workplace pilots announced in the *Choosing Health* White Paper to all Departments. See also our response to recommendation 35.

**Recommendation 37 (paragraph 334): We recommend that the Activity Coordination Team's reports explicitly link its activity to the Government's specific targets on activity both in schools and in the community.**

ACT brings together the work of DH, DCMS, DfT, ODPM, DfES, DEFRA, HM Treasury, and the Department for Work and Pensions on physical activity and has enabled the production of the cross-Government proposals set out in the *Choosing Health* White Paper including those relating to schools and the community. ACT will also play a key role in production of the Physical Activity Plan next Spring.

**Recommendation 38 (paragraph 337): We recommend that a survey of action on obesity, both at PCT and SHA level, should be undertaken as part of the ongoing work on the forth coming white paper on public health.**

The Dr Foster report on the prevention and management of obesity (October 2003) found that second line treatments (pharmaceutical and surgical) were better established than first line (especially nutrition and physical activity).

Building on the conclusions of the Dr Foster report we have small scale evidence provided by research commissioned by DH into attitudes towards, and practice of, prevention in primary care (*Opinion Leaders Research, 2004*[1]). This showed that:

- whilst primary care staff felt that the provision of prevention and management services for people who were overweight or obese was important, they felt ill-equipped to provide those services and many were unclear about the roles and responsibilities of different primary care staff;
- some health care professionals, including GPs, are uncomfortable about raising the issue of weight with patients, they are not confident about the advice they should be giving, particularly on physical activity and for some, they do not yet see the prevention and management of obesity as a priority for them; and
- many health care professionals are not aware of available services to which they can refer people.

These findings may be because the people interviewed have not yet made the connection between obesity and acute health issues or because it was not part of their training and they do not know how to tackle it. The research also found that PCTs and primary care staff felt that a national model for the provision of obesity services on which Strategic Health Authorities (SHAs), PCTs and health professionals could build was essential.

**Recommendation 39 (paragraph 343): We feel strongly that Primary Care Trusts should be taking a more active role in preventing obesity, and urge the Government to ensure that PCTs have the capacity, competency and incentive to fulfil their crucial obligation to safeguard the public health of the local communities they serve. We also endorse the recommendation of the Wanless report that the Healthcare Commission should develop a robust mechanism for assessing performance of both PCTs and Strategic Health Authorities with respect to public health.**

1 Report to the Department of Health – attitudes towards and practice of prevention in primary care: a qualitative study, OLR June 2004

**Recommendation 43 (paragraph 363): We recommend that the Government provides funding for the large scale expansion of obesity services in secondary care, underpinned by careful management to ensure that the service provision is matched to need. The Government's maximum waiting time targets must apply to all of these services.**

**Recommendation 46 (paragraph 372): We recommend that the Government take urgent steps to tackle this subtle deprioritisation of obesity wherever it occurs in the NHS.**

We have already placed the prevention and management of obesity at the heart of many of our priority areas, including the NHS Plan, the NSFs for CHD, Diabetes and Children, and the new *NHS Improvement Plan* (2004), which raises the profile of prevention and preventive services, including obesity, within the NHS.

The NHS performance management framework and associated Local Delivery Plan lines have a significant role to play both in helping the NHS to drive health improvement at a local level, and also in improving the quality of local data on key health of the population indicators. This year, for the first time, the DH is requiring the NHS to return local data on the prevalence of obesity in children and on obesity status among adults. Local action by PCTs will form an important strand of work towards the obesity PSA target. Action on obesity will be integral to the Local Delivery Plans made by PCTs and SHAs and their performance will be monitored.

Following publication of *National Standards, Local Action* the DH issued a technical note to the NHS on Local Delivery Plans to support the delivery of national targets. We will issue a supplementary technical note to the NHS, reinforcing the priorities of the *Choosing Health* White Paper and outlining the requirement to plan services to deliver reductions in health inequalities and improvements in obesity status, including among children.

From 2005 there will be a new performance framework for the NHS and social care, described in *Standards for Better Health*. This set out the level of quality all organisations providing NHS care will be expected to meet or aspire to across the NHS in England. One of the seven domains in *Standards for Better Health* is public health.

The independent Healthcare Commission is responsible for developing assessment criteria to be used to determine whether core standards have been met, and judging progress against developmental standards. The annual performance ratings will be based on annual reviews of NHS organisations and those providing services to the NHS and will draw on thematic reviews of particular functions and services, including those for health improvement and public health.

PCTs already have a range of guidance available to use when working with patients who are overweight or obese. This includes the National Quality Assurance Framework (NQAF) for Exercise Referral, the 5 A DAY handbook for community initiatives, and the Health Development Agency (HDA) report on effective interventions for obesity prevention and management. They also have guidelines issued by the National Institute for Clinical Excellence (NICE) on both the use of drugs (2001) and surgery (2002).

The DH has commissioned NICE to prepare definitive guidance on prevention, identification, management and treatment of obesity and this is due to be available in 2007. The new guidance will build on work undertaken to produce advice for PCTs, and others, in order to ramp up service delivery in the light of the new PSA targets and anticipated increased demand for services.

We will develop a comprehensive "care pathway" for obesity, providing a model for prevention and treatment More specifically the prevention and treatment of obesity will ensure that:

- we have coordinated activity on obesity prevention and management in each PCT for both adults and children with a range of appropriately trained staff – to include health trainers, school nurses, health visitors, community nurses, practice nurses, dieticians and exercise specialists. Services may also be drawn from the voluntary and independent sector;
- there are clear referral mechanisms to specialist obesity services which will be staffed by multidisciplinary teams with specialist knowledge and training in obesity management; and
- in addition to specialist services there will also be trained staff who can work in different settings such as schools, leisure services and the community, working alongside obesity prevention and management experts within the overall whole system approach to obesity within a PCT.

We are also going to:

- commission production of a "weight loss" guide, to set out what is known about regimes for losing weight and help people select the approaches that are healthy and are most likely to help them to lose weight and then maintain a more healthy weight;
- commission further studies to support development of new approaches where there are gaps in the evidence base within the new framework for research
- support the setting up of a "national partnership for obesity". The partnership will act to promote practical action on the prevention and management of obesity and as a source of information on obesity (for both diet and physical activity) and evidence of effectiveness;
- as part of the National Health Competency Framework we will allocate new funding for training, management, provision of evidence based obesity prevention and treatment, based on National Occupational Standards for obesity; and
- develop a Patient Activity Questionnaire, which will be available by the end of 2005 to support NHS staff and others to understand their patient's levels of physical activity and assess the need for interventions, such as exercise referral.

The additional funding that will go to PCTs from 2006 will help them strengthen primary care capacity to prevent weight gain and tackle obesity, and to develop services to respond to patient needs across the whole care pathway.

**Recommendation 40 (paragraph 355): The Government should ensure that within each PCT area there is at least one specialist primary care obesity clinic, probably supported by a range of different health professionals, to which GPs can refer any patients they identify as needing specialist support to address a developing or existing weight problem.**

**Recommendation 41 (paragraph 356): We recommend that, in establishing primary care obesity clinics, PCTs should fully explore the possibilities of using less traditional models of service delivery, involving clinicians from across the professional spectrum, from nurses to pharmacists to dieticians. The full range of interventions available to treat obesity includes diet, lifestyle, medical treatment and surgical treatment.**

**Recommendation 42 (paragraph 357): We also took some interesting evidence from commercial slimming organisations. We recommend that the NHS examine whether their expertise can be brought to bear in devising strategies to combat obesity holistically.**

Each PCT area will need a specialist obesity service with access to a dietitian and relevant advice on behavioural change. PCTs do not need to commission all these elements from NHS providers, but should develop innovative clinical models that will help support evaluation of different approaches to delivery of obesity services at local level, for example quality assured, commercial diet providers and leisure centres. Local partnerships with the voluntary and community sectors, local authorities, the leisure industry and other alternative service providers will be able to enhance capacity and the new primary care contracting arrangements support this.

In addition, the independent sector may have a key role in providing effective behaviour change programmes in ways that are more acceptable than traditional NHS care to some groups of patients. We will test this as part of a procurement for a "year of care" for diabetic patients.

Another model we will test is to use the Healthy Communities Collaborative (HCC) principles in the prevention and management of obesity. This will build on existing HCC work on diet and nutrition, and accidents.

The NICE guidance on the prevention, management and treatment of overweight and obesity, due for publication in 2007, will address services both inside and outside the NHS. Whilst the guidance will not make specific recommendations about services outside the NHS, it will provide the NHS with advice on working with non-NHS partners. It will also provide advice on effective interventions in the prevention of overweight and obesity and weight maintenance support for those who have lost weight.

The guidance will include advice on the role of non-pharmacological interventions. Where there is good evidence of effectiveness, the following interventions will be considered:

- dietary advice including the role of low-fat, low-carbohydrate and very low-energy diets, the role of meal replacements and the role of 'slimming clubs'
- physical activity
- psychological therapies
- professionally organised alternative therapies

The registered stakeholders for the guideline – which includes commercial slimming organisations – have been asked to submit evidence in advance of the production of reviews of the evidence base that will be considered by the guideline development group.

**Recommendation 44 (paragraph 366): Steps must be taken to ensure that obese children and young people have prompt access to specialist treatment wherever they live.**

**Recommendation 45 (paragraph 369): We recommend that throughout their time at school, children should have their Body Mass Index measured annually at school, perhaps by the school nurse, a health visitor, or other appropriate health professional. The results should be sent home in confidence to their parents, together with, where appropriate, advice on lifestyle, follow-up, and referral to more specialised services. Where appropriate, BMI measurement could be carried out alongside other health care interventions that are delivered at school, for example inoculation programmes.**

The "care pathway" for obesity will ensure that we have coordinated activity on obesity prevention and management in each PCT for both adults and children.

The HDA has published an evidence briefing on the effectiveness of interventions for the management and treatment of obesity in adults and children. From the evidence available, it is clear that specific approaches are required for children, such as family-based therapy. The NICE guidance due in 2007 will include advice for the prevention, management and treatment of overweight and obesity in children aged two years and over.

Children are particularly at risk and need a healthy start in life, which is why we introduced the national PSA target on obesity. The NSF on *Children, Young People and Maternity Services* also includes action on obesity.

Another component of the strategy for integrated service delivery is the development of extended schools. Our expectation is for all primary and secondary schools to develop as extended schools over time. In partnership with PCTs and other agencies, extended schools can provide, or offer referral to, accessible health and social care to pupils, their families and the community. Extended schools can also provide opportunities for children and their parents to practice healthy lifestyles through opportunities for physical activity and classes, for example on cooking, outside school hours.

We need to build a culture of participation where children and young people are involved in the range of issues and decisions that affect them. We are introducing Children's Health Guides as part of the new *Child Health Promotion* programme. These health plans will be the foundation for personal health guides (PHGs) for life.

We see a new and relevant role for school nurses on a wider scale than in recent years. The Chief Nursing Officer will work with nurse leaders and the DfES to:

- modernise and promote school nursing; and
- develop a national programme for best practice that includes reviewing children and young people's health and supporting the use of children's PHGs.

We are providing new funding so that by 2010 every PCT – working with children's trusts and local authorities – will be resourced to have at least one full-time, year round, qualified school nurse working with each cluster or group of primary schools and the related secondary school, taking account of health needs and school populations. School nurses and their teams will be part of the wider health improvement workforce described in the *Choosing Health* White Paper. Roll out will start from 2006-07 in the 20% of PCTs with the worst health and deprivation indicators.

To support the development of local data sources, and improvements in data quality, the DH will continue to work closely with the DfES to develop appropriate systems for recording lifestyle measures, for example obesity through weight and height measurements, among school age children.

We will commission further studies to support development of new approaches for tackling obesity where there are gaps in the evidence base within the new framework for research discussed in *Choosing Health*. This will include production of specific guidelines for children's exercise referral in line with the NQAF for Exercise Referral.

**Recommendation 47 (paragraph 379): The Government must devote protected resources to ensuring that bariatric surgery is available to all those who need it, and should issue guidelines for the strategic development of services across the country, to eliminate the current postcode provision of obesity surgery.**

The care pathway for obesity we will develop will include referral for surgery where appropriate.

NICE published two appraisals in March and November 2001 on the use of Orlistat and Sibutramine for the treatment of obesity in adults. NICE published a further appraisal on surgical interventions for the morbidly obese, in July 2002. NICE recognised that it would take some considerable time for the NHS to build up its capacity to deliver this treatment – its indicative figures suggest a gradual increase in the use of surgical procedures over an 8-year period. It was therefore considered necessary to exempt this appraisal from the direction requiring NHS bodies to provide funding for treatments recommended by NICE within 3 months of the publication of the guidance.

Following discussions with consultees, the review of these appraisals has been incorporated into the on-going NICE guideline on the prevention, identification, assessment and management of overweight and obesity in adults and children, due for release in 2007.

There is already a steady upward trend in the number of surgical interventions. The following data taken from the Department of Health's *Hospital Episode Statistics* shows the year on year figures for the number of Finished Consultant Episodes (FCEs) with any operation performed, where the primary diagnosis was obesity:

| Year | FCEs |
|---|---|
| 1996-97 | 277 |
| 1997-98 | 282 |
| 1998-99 | 395 |
| 1999-00 | 392 |
| 2000-01 | 496 |
| 2001-02 | 440 |
| 2002-03 | 538 |

**Recommendation 48 (paragraph 382): Advances in medical and surgical treatment of obesity should be supported by equivalent development of services to address the psychological and behavioural aspects of obesity. All those receiving treatment for obesity, whether in a primary or secondary care setting, should have access to psychological support provided by an appropriate professional, whether this is a psychiatrist, psychologist, psychotherapist, counsellor, or family therapist.**

We recognise the far-reaching psychosocial implications that obesity can have for both adults and children, including reduced self-esteem, increased risk of depression, and a sense of social isolation and humiliation arising from practical problems.

The care pathway for obesity will encompass a range of treatment programmes including:

- specific dietary and activity advice and exercise referral;
- behaviour change therapy geared to the needs of individuals, for example family-based action for children;
- long-term support for and review of chronic cases;
- targeted use of drugs and surgery where appropriate; and
- regular monitoring of progress and of related disease.

We recognise that a range of health care professionals and other staff exist who could have a role in obesity prevention and management. As part of the work to develop the care pathway we shall identify what might be expected of each group, as well as of obesity specialists and clinical staff.

**Recommendation 49 (paragraph 393): The NHS has a responsibility both to take strategic actions to prevent obesity, as part of its public health remit, and to provide adequate treatment for those already suffering from overweight or obesity, as it would for those suffering from any other medical condition. It appears to us to be failing in both of these areas, and this needs to change as a matter of urgency.**

**Recommendation 50 (paragraph 396): It is essential that, as part of the Government's wider strategy to tackle obesity, a dedicated framework document is produced to emphasise to a largely sceptical NHS the full scale and seriousness of this problem. This document should build on existing work in this area, drawing together and emphasising the obesity measures already set out in the National Service Frameworks, and linking in with the ongoing work of NICE. It must re-introduce realistic but stretching targets for reducing the prevalence of obesity and overweight over the next ten years, underpinned by more detailed, service-based targets, in particular bringing waiting times for specialist medical and surgical obesity services in line with all other NHS specialities. PCTs should be stringently performance-managed on their delivery of these targets.**

We have acknowledged that the current provision of obesity services across the NHS is variable, which is why we intend to develop the care pathway. We want to see a whole-system approach to obesity in the NHS – a higher level of service delivery for the prevention, management and treatment of obesity. We expect the NHS to act on existing guidance and to prepare to be ready to implement the new NICE guidance on the prevention, identification, management and treatment of obesity when it becomes available in 2007.

The Delivery Plan for the *Choosing Health* White Paper that we will publish early next year will make clear the accountability for the commitments in the White Paper and the action that needs to be taken. It will spell out the particular roles and responsibilities for health improvement of all health and social care organisations and, where we have reached agreements, for organisations in the rest of the public, private and voluntary sectors. As part of this delivery programme we will also – as previously promised – publish discrete national delivery plans focusing on nutrition and activity:

- the Food and Health Action Plan
- the Physical Activity Plan

These will set out how and when Government, its agencies and others will deliver their commitments to improve the nation's diet and increase activity, including those commitments identified in the White Paper and other relevant departmental plans.

**Recommendation 51 (paragraph 403): It is clearly important that some steps are taken to monitor the effectiveness, and the cost-effectiveness of what we propose, in line with the recommendations of the Wanless report on public health. We would like the National Audit Office to conduct further work on the value for money implications of measures taken to combat obesity, since this will be one of the greatest pressures on NHS resources over the coming decades. We recommend that the Department undertake urgent work to establish better estimates of the cost of treating diseases to allow it to manage its resources more effectively.**

The analysis in the National Audit Office (NAO) 2001 report remains the authoritative source of cost estimates on obesity in England. The NAO also reviewed the work of the NHS in addressing obesity and looked at initiatives across government to tackle the problem. The Government agrees that further NAO work on the costs and benefits, both human and financial, of action taken would be helpful. The Department of Health is exploring the scope for such an analysis within the context of the obesity PSA target delivery plan.

**Recommendation 52 (paragraph 411): Our concluding thought is that the Government must be prepared to act and intervene more forcefully and more directly if voluntary agreements fail. We recommend that the Government should allow three years to establish those areas where voluntary regulation and co-operation between the food industry and Government have worked and those where they have failed. It should then either extend the voluntary controls or introduce direct regulation.**

We note the Committee's recommendation and have already demonstrated in the *Choosing Health* White Paper that we are prepared to introduce legislation if voluntary measures fail, for example to restrict further the advertising and promotion to children of those foods and drinks that are high in fat, salt and sugar. We have also committed to pressing vigorously for progress before and during the UK presidency of the EU in 2005 to simplify nutrition labelling and make it mandatory on packaged foods. We firmly believe that the food industry can play an important role in helping us all to make healthier choices, and we are keen to work with them to achieve the desired changes to the nation's eating habits. We know that many companies and organisations are committed to making a positive contribution to improving the nation's diet whether by provision of healthier foods, improved labelling, and new approaches to portion sizing or other initiatives. We recognise and welcome the commitment and progress that the food industry has already made – for example in the Food and Drink Federation's *Food & Health Manifesto*, which sets out their members commitment "to working constructively with Government" on a whole range of issues. We look forward to working constructively with the industry to co-ordinate their contribution with that of the Government and others and to build on the progress already made.

## List of Abbreviations

| | |
|---|---|
| ACT | Activity Co-ordination Team |
| ASA | Advertising Standards Authority |
| CAP | Common Agricultural Policy |
| DCMS | Department for Culture, Media and Sport |
| DEFRA | Department for Environment, Food and Rural Affairs |
| DfES | Department for Education and Skills |
| DfT | Department for Transport |
| DH | Department of Health |
| EFS | Expenditure and Food Survey |
| FSA | Food Standards Agency |
| HDA | Health Development Agency |
| IiP | Investors in People |
| NDNS | National Diet and Nutrition Survey |
| NICE | National Institute for Clinical Excellence |
| NQAF | National Quality Assurance Framework |
| NSF | National Service Framework |
| ODPM | Office of the Deputy Prime Minister |
| Ofcom | Office of Communications |
| Ofsted | Office for Standards in Education |
| PCT | Primary Care Trust |
| PE | Physical Exercise |
| PSA | Public Service Agreement |
| SHA | Strategic Health Authority |

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
*175409 12/04*

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